Invest in ME
PO Box 561, Eastleigh SO50 OGQ, Hampshire, UK
Telephone: 02380 251719 – 07759 349743
Web: www.investinme.org Email: info@investinme.org
Charity Nr 1114035

INVEST IN ME RESPONSE TO NATIONAL INSTITUTES OF HEALTH PATHWAYS TO PREVENTION WORKSHOP: ADVANCING THE RESEARCH ON MYALGIC ENCEPHALOMYELITIS/ CHRONIC FATIGUE SYNDROME DRAFT EXECUTIVE SUMMARY

January 2015

Invest in ME would like to thank the NIH for the opportunity to submit comments on this draft report [**1**].

Invest in ME (IiME) is a UK charity (charity number 1114035) established in 2006 to educate the public and media about Myalgic Encephalomyelitis (ME) and raise funds for fundamental biomedical research into ME. We have links internationally and are current chair of the European ME Alliance, an umbrella organisation of 13 national European patient groups working together to improve awareness of ME. IiME have so far organised nine annual international ME/CFS conferences and four research colloquiums in London, UK, to allow researchers, clinicians, patient groups and patients to learn about the latest research, form collaborations and share experiences to advance research into this condition.

The charity strongly believes in international biomedical research collaboration and have initiated possibly the two most important research projects for ME in the UK – a gut micriobiota study [2] and a project leading to a UK clinical trial using rituximab to treat ME patients [3].

In the UK patients prefer to use the term ME to differentiate from the term CFS which is favoured by those using the Oxford criteria or who wish to use as broad a possible an umbrella to describe their particular interests. In this document we will use ME/CFS from here on to match your terminology and also that used in the Canadian Consensus Criteria for which IiME is UK distributor of the printed version).

Below are comments that we have concerning the draft document.

We conclude this document with a summary and our recommendations.

IiME Comments

Here are the charity's comments -

Lines 2-4:

> "Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) is a chronic, complex, multi-faceted condition characterized by extreme fatigue and other symptoms that are not improved by rest.
>
> **IiME comment:**
>
> We are unsure why "extreme fatigue" is highlighted here and all other symptoms are bundled together as "other symptoms" especially when later in the document fatigue is recognised as not necessarily being the main symptom.
>
> It may be better to replace line 3 with –
>
> > "…faceted condition characterized by multiple symptoms that are not improved by"

Lines 7-11:

> "ME/CFS results in major disability for a large proportion of the people affected. Limited knowledge and research funding creates an additional burden for patients and health care providers. Unfortunately, ME/CFS is an area where the research and medical community has frustrated its constituents, by failing to assess and treat the disease and by allowing patients to be stigmatized.
>
> **IiME comment:**
>
> We strongly agree that ME/CFS leads to major disability and patients feel frustrated at no medical discipline taking responsibility for this condition despite it being classified as a neurological illness since 1969.
>
> However, the NIH have to take a portion of the responsibility for this state of affairs as "limited knowledge and research funding" directly causes the ignorance amongst the healthcare profession and leads to failure "…to assess and treat the disease and by allowing patients to be stigmatized".
>
> NIH funds research and therefore carries some of this responsibility for the state of affairs.

Lines 38-43:

> "The Oxford criteria (published in the Journal of the Royal Society of Medicine in February 1991) are flawed and include people with other conditions, confounding the ability to interpret the science. The lack of a consistent, specific, sensitive diagnostic test and set of criteria has hampered all downstream research on pathogenesis and treatment, causing harm and preventing ME/CFS from being considered as a distinct pathologic entity."
>
> **IiME comment:**
>
> We agree with the statement that the Oxford criteria "hampered all downstream research on pathogenesis and treatment, causing harm and preventing ME/CFS from being considered as a distinct pathologic entity". We have stated for many years that the Oxford criteria are flawed for ME research and research related to ME which has used these criteria need to be ignored as evidence for this document.

Lines 51-53:

"Small sample sizes, the inclusion of participants with differing symptoms across studies, and the lack of inclusion of the homebound, rural residents, and a research focus on men limits the applicability of current studies."

IiME comment:

Really those funding bodies including the NIH, the UKMRC, Departments of Health etc. must take responsibility for this state of affairs.

Lines 55-57:

"All this leads to inconclusive results and a lack of knowledge of ME/CFS prevalence (i.e., how many people have ME/CFS), incidence (new cases per year), and potential causes and treatments."

IiME comment:

A study by Nacul at al. shows the variation in prevalence rates of 0.03 to 0.19% in three regions in England (UK) depending on criteria used. The overall estimated minimal yearly incidence rate was 0.015%. This study was not part of the review as it did not seem to fit your criteria [4].

Lines 58-59:

"Fatigue has been the defining focus of recent research, but many other symptoms need to be explored, primarily neurocognitive deficit ("brain fog"), post-exertion malaise, and pain."

IiME comment:

We agree - which makes it stranger that the report specifically only highlighted fatigue in line 3. Not all ME/CFS patients find fatigue as their main or most debilitating symptom and too much research has been performed concentrating on this one symptom alone.

Fatigue is a symptom of numerous conditions and it is not specific for ME/CFS. Post Exertional Malaise is a hallmark symptom of ME/CFS and it has been shown in two day VO2Max exercise testing and is accepted as objective proof of physical disability. Larger studies are needed to find out whether this could be used as a biomarker and to find out whether there are clear subgroups for reasons for the drop in performance as indicated by the Keller et al. study [5, 6, 7].

Lines 65-73:

"Often, patients with ME/CFS are labeled as lazy, deconditioned, and disability-seeking; this hampers scientific progress. Both society and the medical profession often treat patients with ME/CFS with disdain, suspicion, and disrespect. Patients are frequently treated with psychiatric and other inappropriate drugs that may cause harm. Patients usually have to make extraordinary efforts, at extreme personal costs, to find a physician who will correctly diagnose and treat ME/CFS symptoms. In addition to high medication costs, the debilitating effects of ME/CFS can result in financial instability due to the physical consequences of the illness (e.g., the loss of employment, home, and other basic necessities). All of these factors contribute to the poor quality of epidemiologic studies.**"**

IiME comment: All of these factors can be attributed to the lack of any serious strategy to resolve the illness – which then allows flawed research to be funded and which also leads to misinformation and poor education about this illness being perpetuated.

Listen to the patients – an old adage but one which has until now not echoed in those rooms where decisions are made about research into ME/CFS.

Lines 92-95:

"Although psychological repercussions (e.g., depression) often follow ME/CFS, this is not a psychological disease in etiology. A multitude of symptoms are associated with ME/CFS, with substantial overlap with other pathologic diseases (e.g., fibromyalgia, major depressive disorder, and a variety of chronic pain or inflammatory conditions)."

IiME comment:

Good to read it clearly stated that this is not a psychological disease.

The World Health Organisation (WHO in Europe) has classified ME as a neurological illness since 1969. It is the proponents of the biopsychosocial paradigm that try to promote the notion that ME/CFS can be classified in two separate codes either as neurological or mental illness depending on the diagnostician's opinion which is grossly misleading and contributes to the problems patients face at all levels of society [8].

However, care should also be taken not to add on co-morbid diagnoses such as fibromyalgia or mood disorders just because ME/CFS patients report pain or feel a bit down as these can form just part of the normal ME/CFS symptomatology.

Lines 95-97:

"Focusing on fatigue alone may identify many ME/CFS cases. However, this symptom taken in isolation fails to capture the essence of this complex condition."

IiME comment:

Exactly. We entirely agree.

Lines 113-117:

"Existing treatment studies (cognitive behavioral therapy [CBT] and graded exercise therapy [GET]) demonstrate measurable improvement, but this has not translated to improvements in quality of life (QOL). Thus, they are not a primary treatment strategy and should be used as a component of multimodal therapy. Overall, agreeing on a case definition and clarifying comorbidities could launch bench-to-bedside science."

IiME comment:

It is at this point that we begin to wonder about the real agenda.

We strongly disagree with the statement that CBT and/or GET demonstrate measurable improvement that makes a real difference in patients' lives. In fact a large study in Belgium that collected data of 1655 patients attending four reference centres between 2002 and 2004 demonstrated that participants' physical capacity did not change, their employment status decreased and the percentage of patients living off sickness allowance increased at the end of such therapies [9].

Also a 2007 study by Knoop et al showed that "CBT leads to a reduction in self-reported cognitive impairment, but not to improved neuropsychological test performance. The findings of this study support the idea that the distorted perception of cognitive processes is more central to CFS than actual cognitive performance."[10].

We are very concerned about the term multimodal therapy. What does it mean and is there any evidence for such a therapy being useful for ME/CFS?

CBT and GET should not form any more part of a treatment strategy for ME/CFS than it is for other neurological illnesses such as MS or Parkinson's disease for example.

The lamentable (some would say farcical)-PACE trial in the UK that used the Oxford criteria has conclusively demonstrated the total waste of money behind these ineffectual therapies.

The emphasis should be on researching and treating the core illness and not just concentrating on comorbidities which could often be avoided if the condition was treated by knowledgeable physicians to begin with.

We emphasise this point!

Lines 130-134:

"In general, little attention was given to how self-management may empower and improve health and QOL for patients with ME/CFS. Physicians are inadequately trained to instruct patients in self-management skills (e.g., pacing, realistic goals, physical self-awareness, basic rights, understanding emotions, exercise, relaxation), and there is a lack of data demonstrating the efficacy of self-management on health outcomes."

IiME comment:

We totally disagree.

ME/CFS patients have been self-managing for decades, by necessity, and are better at doing so than many other patient groups. Even very severely ill bed bound patients may often be looked after by family members in their own homes with little supervision from health care professionals or social services.

It is not self-management skills that patients are looking for when they visit their doctors. They need honest information, advice, support and follow ups to ensure there are no missed diagnoses – and hope that the miserable record of proper research may be overturned in order to provide a future.

Support for practical matters such as education, employment, social care and help with benefits would be useful in the early stages of the illness to avoid mildly affected patients ending up becoming severely affected due to overexertion resulting from ignorance about ME/CFS or negligent advice.

If the illness was taken seriously and patients treated with respect at first point of contact then there would be less need for treating some of the subsequent comorbidities.

There needs to be a clear message to the research community that the NIH considers ME/CFS a physical disease and the peer reviewers and funding committees that decide upon grant applications should hold the same view.

Lines 134-138:

"The focus on exercise programs has further stigmatized and discouraged research participation. In many cases, lack of instructions or guidance for including graded exercise therapy often causes additional suffering, creating fear of harm from a comprehensive self-management program that may include some physical activity (e.g., mild stretching)."

IiME comment:

Patients do not have fear of harm and they have nothing against common sense advice but they do object to proscriptive CBT and GET programmes that are patronising and based on flawed research.

The group should also be aware of harms caused by CBT and GET.

This aspect has been explored in a paper titled "Reporting of Harms Associated with Graded Exercise Therapy and Cognitive Behavioural Therapy in Myalgic Encephalomyelitis/Chronic Fatigue Syndrome**"** by T. Kindlon and he states -

> "Across different medical fields, authors have placed a greater emphasis on the reporting of efficacy measures than harms in randomised controlled trials (RCTs), particularly of nonpharmacologic interventions."[11].

Each chronically ill patient be it ME/CFS, cancer or any other illness learns to cope in their own way and the most important thing for them is to receive support and honest and factual information to be able to adjust to their lives accordingly in the absence of effective treatments or a cure.

ME/CFS patients tend to prefer research into the core aspects of the illness so that the information given to them by doctors would be based on facts rather than opinion, assumptions or vested interests.

There is no problem in recruiting patients for such research. As a charity that funds biomedical research into ME Invest in ME can categorically state that recruitment for research and trials is no issue.

Lines 169-177:

"Research priorities should be shifted to include basic science and mechanistic work that will contribute to the development of tools and measures such as biomarker or therapeutics discovery. The following questions need to be answered:

• What is the pathogenesis of ME/CFS? What is the role of virologic mechanisms, especially herpes viruses? Does mononucleosis lead to ME/CFS in adolescents?

• What is the role of other pathogenic agents?

• Is this a genetic disease? Is there a gene-environment interaction?

• Is ME/CFS a spectrum disease?

• Are different pathways responsible for different symptoms?"

IiME comment:

The research priorities should not just shift to include basic science and mechanistic work but this should be one of the main areas of research.

Once there is a biomarker that is reproducible then the field could move forward quickly.

The message of ME/CFS being a physical disease and not a psychological one should be kept in mind when committees and peer reviewers are chosen to decide upon grant applications.

Lines 178-185:

Future Directions and Recommendations

"ME/CFS is a chronic, complex condition of unknown cause and with no cure. We have learned some about the mechanisms of the disease, but nothing has improved the lives of the patients. Overall, there has been a failure to implement what we already know for patients with ME/CFS while it steals their health and well-being."

IiME comment:

The biggest failure in the whole history of ME/CFS has been the lack of anyone in authority taking responsibility for this area of medicine and patients have been left to manage as best as they can.

In the UK the Medical Research Council (MRC) and those in the MRC controlling policy toward ME have been seriously negligent. The NIH must take its share of the blame also.

Researchers need to know that there is funding for them to be able to commit their careers to researching this group of patients.

Lines 183-184:

"The subjective nature of ME/CFS, associated stigma, and the lack of a standard case definition has stifled progress."

IiME comment:

We suggest this could be changed to –

> "The subjective nature of ME/CFS, associated prejudice and ignorance about the disease, and the lack of a standard case definition has stifled progress."

Lines 192-194:

"Potential conflicts of interest among investigators need to be properly vetted, discussed, and addressed by all stakeholders."

IiME comment:
This is of paramount importance.
In the UK the example of the appalling complicity of the MRC in allowing vested interests to be involved in ME research must be a thing of the past.

Lines 202 -208:

"1. Define disease parameters. Assemble a team of stakeholders (e.g., patients, clinicians, researchers, federal agencies) to reach consensus on the definition and parameters of ME/CFS. A national and international research network should be developed to clarify the case definition and to advance the field. There are tremendous opportunities on which we have not yet capitalized to learn across disciplines and from other diseases such as Gulf War Syndrome, Lyme disease, fibromyalgia, multiple sclerosis, and Parkinson's disease, to determine commonalities and differences."

IiME comment:

There have been years of meetings and working groups (CFS Advisory committee has submitted recommendations several times) and so-called expert panels and this report should not lead to yet another committee with no real action, and no power.

ME/CFS patients need research into their disease and researchers need substantially more funding to be able to do meaningful research in a progressive manner.

Invest in ME has been facilitating international networking for nine years and it is starting to pay off but funding is needed to keep the networking going.

In 2012 we held the first ME/CFS Clinical Autoimmune Working Group meeting in London, UK, in collaboration with The Alison Hunter Memorial Foundation (AHMF) of Australia and that colloquium included researchers from other disciplines such as MS, Rheumatology and oncology [12]. This was a real example of international collaboration and networking – organised by patients and carers.
The consensus from that meeting was that the rituximab trial by Fluge et al. in Norway provided the best leads for future research [13].

In 2013 our 3rd colloquium resulted in Invest in ME setting up a project to conduct a UK rituximab clinical trial to allow collaboration and sharing of experiences with the Norwegian researchers, and others.

In 2014 our 4th Biomedical Research into ME Colloquium had almost 50 biomedical researchers from nine countries involved and many new initiatives were created.

Invest in ME are now organising our fifth colloquium – a two day affair.

These are biomedical research meetings – aligned with our biomedical research conferences. We have a basis for international research and networking – it doesn't need to be reinvented and it doesn't need to be described as though it is a new idea.

So action is needed not merely words.

See our Conclusion later in the document.

Lines 271-276:

"Patients often choose clinical trials or complementary and alternative medicine because effective treatment is not available and because traditional health care is not meeting their needs. Studies investigating homeopathy, non-pharmacologic, complementary, and alternative medicine treatments are needed. Studies addressing biopsychosocial parameters (including the mind-body connection), function, and QOL should be encouraged."

IiME comment:

It is quite odd to see recommendations like this within the context of your previous comments of ME/CFS not being of psychological aetiology, lacking in basic research or patients experiencing stigma from the diagnosis, including social isolation and judgement (Lines 121-122)**.**

Encouraging studies into homeopathy, alternative treatments or mind-body connections at the same time as declaring lack of basic research would only add to this stigma – or prejudice. There is no more need for such studies in ME/CFS than there is for cancer, MS or Parkinson's disease for example.

Scarce research funding for ME/CFS should not be used for yet more trivialities.

The Fluge et al. rituximab research did not fit your criteria of at least 12 week duration but it has captured the interest of renowned researchers outside the field such as Invest in ME's advisor, Professor Jonathan Edwards, who was instrumental in getting rituximab accepted as treatment for rheumatoid arthritis.

If that research can identify differences between responders and non- responders then that in itself would help move the field forward considerably.

ME/CFS patients are keen on taking part in clinical trials such as rituximab or Ampligen as that is their only chance of getting 'real' treatment, of being taken seriously, of being treated with respect.

What is meant here by the term biopsychosocial? If it is the same paradigm that has been promoted in the UK and rest of Europe since 2005 then we can inform you that it has not worked and patients deserve better than this [14].

We have written before that

> "….we feel it is impossible to marry the views of those who believe in the deconditioning/behavioural and wrong illness belief model of ME with those from the biomedical side. The failed PACE Trial has demonstrably proven that the behavioural view of ME cannot deliver and should not continue to command more funding." [15]

To include ME/CFS in a broad collaborative umbrella of other fatigue will do nothing, and produce nothing but delay in treating ME/CFS seriously. A mirage of progress which will waste another few years, forcing patients down a path of complicity by trust – a tried and trusted technique used in the UK to appear to do something but in essence achieve nothing.

Incorporating the biopsychosocial model into any future strategy of ME/CFS research is asking patients to participate in one of the worst possible examples of Stockholm syndrome one can imagine.

As can be seen we feel very strongly about this topic.

We wonder why another agenda seems to be creeping into this document - when the fine and correct words earlier in the document seemed to be moving things in the right direction.

Lines 288-291:

"Although ME/CFS is not a psychiatric disease, exploring psychiatric comorbidities such as depression, anxiety, and fear is critical to improve quality of life. Response burden must be considered; a battery of simplified measures is strongly encouraged, as well as the triangulation of qualitative and quantitative data."

IiME comment:

From our experience doctors who have no expertise in ME/CFS may confuse mood disorders, burn out, overtraining syndrome or excessive tiredness caused by another illness with ME/CFS so it is extremely important to train doctors to be able to diagnose ME/CFS and know the difference between ME/CFS and depression, for example, as well as being aware of the rate of misdiagnosis. Newton et al. research from 2010 showed that 40% of the patients referred to a specialist CFS clinic in the UK turned out to have an alternative diagnosis after careful examination. *"Of the 40% of patients subsequently found not to have CFS the most common diagnosis was fatigue associated with a chronic disease (47% of all alternative diagnoses); 20% had primary sleep disorders, 15% psychological/psychiatric illnesses and 4% a cardiovascular disorder. Thirteen per cent remained unexplained (5.2% of the total referrals)."* [16].

Co morbidities could be lessened by making sure patients are being treated with respect from the first point of contact and onward – basic medical ethics.

Lines 348-351:

"The modest benefit from CBT should be studied as adjunct to other modalities of treatment such as self-management. Future treatment studies should evaluate multimodal therapies. Comparative effectiveness research is also needed."

IiME comment:

Again it is strange to see a recommendation for CBT or therapies that are mainly aimed at behavioural or psychiatric illnesses when you have made it clear that ME/CFS is neither psychiatric nor psychological in aetiology.

Most patients feel that CBT and self-management have been given more than enough attention already and it is time to explore other treatments along the lines of rituximab, gamma globulin, Ampligen, LDN etc.

Self-management can be easily explained in a leaflet and patients support one another on online forums or support groups so resources should be directed toward well designed clinical trials that are based on well thought out hypotheses.

What ME/CFS is lacking is input from various medical experts such as neurologists, immunologists, infectious disease specialists and endocrinologists and pain specialists that can explain the biology of the illness.

You mentioned (lines 38-39, 365-366) that the Oxford criteria are flawed and should be retired. Should you then not remove any research that used those criteria from this review?

What is meant by multimodal therapies? Is there any evidence that such therapies work for ME/CFS?

It is of little wonder that patients suspect there is still a hidden agenda still being set out.

The lines above are inconsistent.

Line 351-352:

"We recommend that the NIH and the FDA convene a meeting on the state of ME/CFS treatment."

IiME comment:

Haven't there been such meetings already? How many more do you need?

There is a list of meetings on the FDA website, the latest one having been held in March 2014 [17].

The document from March 2014 states that regarding the number of drug trials needed to prove efficacy of symptom relief is two independent trials. Why is it then that this draft document is recommending even more CBT/GET/self- management trials when these therapies have already been tested a number of times without any objective measurable improvement [9, 10]?

The UK PACE trial that formed part of your evaluation, despite using the Oxford criteria, was meant to be a definitive trial but it turned out to be so unsuccessful that even the entry criteria and recovery had to be altered to make it seem as value for the enormous £5million expense which was wasted on it [18, 19].

Lines 364-368:

"Specifically, continuing to use the Oxford definition may impair progress and cause harm. Thus, for needed progress to occur we recommend (1) that the Oxford definition be retired, (2) that the ME/CFS community agree on a single case definition (even if it is not perfect), and (3) that patients, clinicians, and researchers agree on a definition for meaningful recovery."

Invest in ME comment:

This we can entirely agree with – something we have stated for many years - and it is good to see it in print. We need a medical speciality and centres of excellence that take responsibility of ME/CFS. For any specific treatment to have a chance to be successful patients need to be carefully phenotyped and it may be that there needs to be an emphasis on personalised medicine rather than trying to find something that fits all patients diagnosed with ME/CFS.

In Conclusion

Thank you for allowing us to submit our comments and we hope our views are taken on board as this affects not only US citizens but everyone diagnosed with ME or CFS across the world.

Whilst it was good to see an outside group of experts trying to get an overview of ME/CFS research it is clearly not possible to do this successfully by just using a scoring method that works for a well-established disease that everyone agrees upon without any knowledge of the underlying history.

It does not help that research into ME/CFS has two opposite viewpoints and this document consequently tries to facilitate both.

This is a major mistake and is contrary to any common sense.

It is illogical to do this and if the statement is made that ME/CFS is a physical disease then recommendations should follow logically from that statement.

If there are co-morbidities they should be dealt with in the same way as one would do with co-morbidities in MS, cancer or Parkinson's disease or any other disease.

We also found it difficult to comprehend what the real objective of this workshop was and we sincerely hope that this is not yet another paper exercise to keep the patient community seemingly happy whilst the authorities do nothing concrete to remedy the current situation.

It would be well for the NIH **NOT** to follow the UK example and repeat the mistakes and failures of the last generation where an insincere effort to change is portrayed as real progress but just results in wasted years. The mediocrity in terms of provision of correct and up to date definitions and guidelines, scientific research and development of treatments and perception of ME is a direct result, and failure, of the policies of the past.

The first part of this report started well describing the situation and what needs to be done. However, it begins to fall apart with instances where inexplicable references to bringing in components which have contributed to the abysmal situation in which ME/CFS patients find themselves.

Whether intentional or actual, or not, It suggests that another agenda may be at play here.

We believe future research into ME must be based on collaboration. But it would seem quite meaningless to base the strategy on those failed policies and directions of the past - which have served patients so poorly and caused such suffering [20].

Research into ME needs a strategic approach - but it may be destined to fail completely by attempting to establish the way forward on foundations which include so much of what has been wrong in the past.

If we are seriously to have a way forward for proper research into ME then we need not just funding, but correctly defined cohorts, standardisation on diagnostic criteria and a collaborative of researchers who will not blur science with politics.

The NIH have a unique possibility to be bold, to fix this problem once and for all.

We therefore suggest the following –

We suggest that the NIH finally and totally abandon all links to the biopsychosocial model with regard to ME research funding.

We also suggest that instead of relying on alternative funding streams elsewhere that the NIH take responsibility themselves for ME/CFS.

We suggest that the NIH invest $50 million per year for the next five years in biomedical research into ME/CFS, and provide correct and current education into the disease which will, in turn, raise appropriate awareness.

This would mean an investment of $250 million over 5 years.

This amount will still be less than the documented annual cost of ME/CFS of $1 billion as noted in line 6.

This will create scores of biomedical research projects, lots of potential international collaboration, new ideas and new skills to enter the ME/CFS research area.

This will facilitate the harnessing of the full potential of academic and research institutes.

This will attract new, young researchers into the field of ME/CFS – this the charity has proven already with our B-Cell/rituximab project with UCL where a young researcher is drawn into this exciting area of research [21]

It will galvanise science and eventually form pockets of expertise which will create the centres of excellence for the future.

We suggest trying this for a 5 year period.

A yearly review of progress can inform every one of the status.

After 5 years of such funding a new conference/workshop/committee can be convened and progress can be examined.

This will provide the best chance possible for resolving this illness to the benefit of patients.

Our guess is that so much progress will have been made in research, in perception and possibly in treatments during that period that the money will be recouped with the added benefit of giving some people their lives back.

The stigma mentioned above – which is actually, in our opinion, just ignorant prejudice created by corrupt organisations and individuals - would be swept away.

$50 million per year is really not much.

After 5 years it will probably have so much momentum that it could carry on by itself through savings in welfare, through new discoveries and, yes, through private donations/funding

To begin this we invite NIH to be represented at our fifth Biomedical Research into ME Colloquium in London on 27-28th May 2015.

The charity will shortly announce the agenda – which will include most of the necessary areas to be looked at as well as the major research initiatives underway or planned.

We invite the NIH to be represented there in London – in order to join our international collaboration effort to resolve this illness in a way that brings hope to patients, brings responsible and proper science to the research area and brings a raising of awareness that will obliterate the monstrous distortions about ME/CFS which have poisoned all chance of making progress in the last generation.

What needs to be emphasised to all – something that is rarely acknowledged and which we see ignored by almost every organisation – is the urgency of the need for action and change.

This is urgent, lives are dependent on it – Treat it as being urgent!

To make progress we need not mere words and a slow undeliberate action plan.

Progress is a fine word – but change is its motivator

To progress this illness we need to make a bold changes.

Invest in ME is a small charity with a BIG cause.

If such a small charity and its supporters can organise ten international conferences with delegates from 20 countries, if it can organise 5 biomedical research colloquiums attracting participants from top research organisations in a dozen countries, if it can initiate possibly the two most important research projects for ME in the UK (22) then the NIH should be able to do far, far better – and in a far shorter period of time.

In the words of the charity's advisor Dr Ian Gibson

> "Things do not have to be the way they are – we can change things."

Let's Do Change.

Let's Do (biomedical) Research.

Let's Do It For ME.

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